PRINTED: 04/09/2009 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		294506	B. WIN	G	 	09/0	4/2008
	OVIDER OR SUPPLIER	ELLC	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 451 S BUFFALO DRIVE, SUITE #100 .AS VEGAS, NV 89117	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
I 000	INITIAL COMMENTS	•	1	000			
	a result of the recertif 9/4/08. The survey we facility's change of loc	ficiencies was generated as ication survey conducted on as conducted due to the cation. Ten active patient records ient records were included in					
	The following Condition	ons of Participation were not					
	CFR 486.56 Governin CFR 485.66 Utilization	ng Body and Administration n Review Committee					
	by the Health Division prohibiting any crimin actions or other claim	clusions of any investigation in shall not be construed as all or civil investigation, as for relief that may be under applicable federal,					
I 505	The following deficier 485.56 GOVERNING ADMINISTRATION		1:	505			
	Based on interview a facility failed to have	not met as evidenced by: nd document review, the a governing body that SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		294506	B. WING	3		09/0	4/2008
	ROVIDER OR SUPPLIER	ELLC		2451	T ADDRESS, CITY, STATE, ZIP CODE S BUFFALO DRIVE, SUITE #100 S VEGAS, NV 89117	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
I 505	and implementing po management and op- governing body failed who was responsible of the facility under the governing body (1505 enforced the facility's (1509); failed to prepaplan under the directia committee consisting governing body and the (1516). The cumulative problems resulted on ensure the provision 485.56(b)(1) ADMINITHE governing body administrator who is a solution of the provision of the governing body administrator who is solved.	sponsibility for establishing licies regarding the eration of the facility. The story of the overall management the authority delegated by the story of and who implemented and policies and procedures are an institutional budget on of the governing body, by the administrative staff the effect of these systemic the facility's inability to of quality health care. STRATOR must appoint an responsible for the overall acility under the authority		505			
	Based on interview a facility failed to ensur appointed an adminis the overall managem authority delegated b Findings include: Interview/Document I On 9/4/08, Employee #2 was the	not met as evidenced by: nd document review, the e that the governing body strator who is responsible for ent of the facility under the y the governing body. Review #2 and #3 indicated that e current administrator who by the governing body in					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		294506	B. WIN	IG		09/0	4/2008
	ROVIDER OR SUPPLIER	ELLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2451 S BUFFALO DRIVE, SUITE #100 LAS VEGAS, NV 89117		2451 S BUFFALO DRIVE, SUITE #100		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
I 508	June, 2008. The facility could produce no documented evidence that Employee #2 had been appointed as administrator by the governing body.		ı	508			
I 509	The governing body r	must appoint an plements and enforces the	I	509			
	Based in interview an facility failed to estable	not met as evidenced by: and document review, the lish policies and procedures sed the management of the ion of services.					
	Finding include:	2i					
	indicated he was not documented evidence	Review istrator (Employee #2) able to locate and provide e of any current P&Ps lagement and the provision					
l 516	provided that were no was no documented of been approved by the	n-site survey, P&Ps were of dated or signed. There evidence that the P&Ps had e governing body. JTIONAL BUDGET PLAN	ı	516			
	under the direction of committee consisting	et plan must be prepared the governing body, by a of representatives of the he administrative staff.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE .DING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		294506	B. WIN	G		09/0	4/2008
	OVIDER OR SUPPLIER	ELLC	•	245	ET ADDRESS, CITY, STATE, ZIP CODE 1 S BUFFALO DRIVE, SUITE #100 S VEGAS, NV 89117		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	RECTIVE ACTION SHOULD BE CORRECTED TO THE APPROPRIATE	
I 516	Continued From page	e 3	1	516			
	Based on document rensure that the institution prepared under the dibody.	not met as evidenced by: review, the facility failed to tional budget plan was irection of the governing					
	Findings include:						
I 535	the facility 9/5/08 wer documented evidence prepared under the d body. 485.58(b) PLAN OF	2007 and 2008 submitted by e not dated. There was no e that the budget plan was irection of the governing FREATMENT TRESIDENT TRE	ı	535			
	This STANDARD is Based on record revieensure the plan of tree	of treatment must meet irements. not met as evidenced by: ew, the facility failed to atment was established by a initiation of treatment of 2 of					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		294506	B. WING		09/	04/2008	
	COVIDER OR SUPPLIER	ELLC	24	EET ADDRESS, CITY, STATE, ZIP COI 51 S BUFFALO DRIVE, SUITE #100 AS VEGAS, NV 89117	DE .		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
I 535	Continued From page	e 4	I 535				
	Patient #5						
	of Status Post Coron (CABG), History Hyp	e unknown) had diagnoses ary Artery Bypass Graft ertension, Diabetes Mellitus, nsient Atrial Fibrillation.					
	pulmonary rehabilitat treatment was started	tion by a physician for ion dated 7/7/08 and d 7/11/08. As of 9/4/08, the ot signed by the physician.					
	Patient #7						
	dated 6/7/08 for card Post Coronary Arter Care/Treatment Plan	e: 7/7/08) had a prescription iac rehabilitation for Status y Bypass Graft. The Plan of for the period of 7/7/08 igned, but not dated by the					
I 546	485.58(d)(1) PROVIS	SION OF SERVICES	I 546				
	physician who provid to the facility before t -The patient's signific -Current medical find	ant medical history. ings. ontraindications to any					
		not met as evidenced by: nd record review, the facility					

Facility ID: NVS99900

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		294506	B. WIN	G		09/0	4/2008
	OVIDER OR SUPPLIER	ELLC	·	STREET ADDRESS, CITY, STATE, ZIP CODE 2451 S BUFFALO DRIVE, SUITE #100 LAS VEGAS, NV 89117			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON SHOULD BE COMPLETION DATE	
I 546	included pertinent pasinformation before tree (Patient #4, #6, #8, #8 Findings include: Document Review Patient #4 Patient #4 (Onset dat prescription for pulmo 6/11/08. There was nhistory and physical exprescription dated 7/2 (Chronic Obstructive Pulmonary rehab (redocumented evidence examination in the che Patient #8 Patient #8 (Onset dat documented evidence examination in the che Patient #8 Patient #8 (Onset dat documented evidence examination in the che Patient #9 Patient #9	e unavailable) had a control of		546			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
294506 B. WING	09/04/2008
NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD HEALTH CARE LLC STREET ADDRESS, CITY, STATE, ZIP CO. 2451 S BUFFALO DRIVE, SUITE #10 LAS VEGAS, NV 89117	DE .
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE COMPLETION DATE
1546 Continued From page 6 On 9/4/08 in the afternoon, Employee #3 indicated the following: - it was not the practice of the facility's medical director to ensure that a history and physical examination was completed for each patient prior to the onset of treatment there have been cases in which the history and physical examination was received after the onset of treatment the facility did not impose a time parameter regarding the date of the history and physical examination, "Just the most recent one." On 9/4/08 in the afternoon, Employee #2 (the administrator) indicated that if the history and physical examination results was not available, the facility started treatment regardless. 1549 485.58(d)(4) PROVISION OF SERVICES 1549 The services must be furnished by personnel that meet the qualifications of §485.70 and the number of qualified personnel must be adequate for the volume and diversity of services offered. Personnel that do not meet the qualifications specified in §485.70 may be used by the facility in assisting qualified staff. When a qualified individual is assisted by these personnel, the qualified individual must be on the premises, and must instruct these personnel in appropriate patient care service techniques and retain responsibility for their activities. This STANDARD is not met as evidenced by: Based on interview, document review, and record review, the facility failed to ensure that adequate personnel was provided for the services offered for 6 of 10 active patients reviewed (#1, #2, #5,	

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		294506	B. WIN	IG_		09/0	4/2008
	OVIDER OR SUPPLIER	ELLC		2	REET ADDRESS, CITY, STATE, ZIP CODE 2451 S BUFFALO DRIVE, SUITE #100 LAS VEGAS, NV 89117	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
I 549	Continued From page	e 7	ı	549			
	Findings include:						
	Interview/Document F	Review					
	On 9/4/08 in the more documented evidence schedule. Employees written staffing sched September, 2008.	e of a written staffing #3 verified there was no					
	the facility that the so Thursdays and Friday	indicated the social worker vacation and was not					
	Record Review						
	Patient #1						
	chart had the followin cancellation of treatm 7/2/08: "Cancelled, no (technician)"	et contained in the patient's g entries indicating lents:					
	Patient #2						
	chart had the followin cancellation of a treat	et contained in the patient's g entry indicating a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		294506	B. WIN	IG _	 -	09/04	4/2008
	OVIDER OR SUPPLIER	ELLC	•	:	REET ADDRESS, CITY, STATE, ZIP CODE 2451 S BUFFALO DRIVE, SUITE #100 LAS VEGAS, NV 89117	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORF PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AI DEFICIENCY)		.D BE	(X5) COMPLETION DATE
I 549	Continued From page	e 8	1	549			
		orker's screening form 7/25/08. The screening was I worker.					
	Patient #5						
	documented evidence screening. There was	te unknown): There was no e of a social worker's s an assessment form ices which was blank.					
	Patient #6						
	documented evidence	s an assessment form					
	Patient #7						
	Patient #7 (Onset dat documented evidence screening.	te: 7/7/08): There was no e of a social worker's					
	Patient #10						
	chart included a chec (support group, Medic signed and dated 8/4 stated, "Acceptance. appointment for me w	vith the Licensed Clinical d like to discuss those items					
		ented evidence that the r met with the patient to f the services.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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I 564	485.60(a)(4) CONTEI The clinical record for pertinent medical hist	r each patient must contain	I	564			
	Based on interview a	eatment was initiated.					
	Findings include: Document Review						
	Patient #4						
	6/11/08. There was n	te unavailable) had a conary rehabilitation dated o documented evidence of a examination in the chart.					
	Patient #6						
	prescription dated 7/2 (Chronic Obstructive Pulmonary rehab (reh	Pulmonary Disease), nabilitation)." There was no e of a history and physical					
	Patient #8						
		e: 7/14/08): There was no e of a history and physical art.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUII		<u> </u>		
		294506	B. WIN	G		09/0	4/2008
	OVIDER OR SUPPLIER EPHERD HEALTH CARE	ELLC		24	EET ADDRESS, CITY, STATE, ZIP CODE 451 S BUFFALO DRIVE, SUITE #100 AS VEGAS, NV 89117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
I 564	Continued From page	e 10	1	564			
	Patient #9						
	· ·	e: 7/25/08): There was no e of a history and physical art.					
	Interview						
I 574	director to ensure that examination was composed to the onset of treatment. There have been caphysical examination of treatment. The facility did not in regarding the date of examination, "Just the On 9/4/08 in the after administrator) indicate physical examination the facility started treatment (485.62(a)(3) SAFETY PATIENTS A fire alarm system we capability must be fur generated by electricity.	g: ice of the facility's medical it a history and physical ipleted for each patient prior ient. ises in which the history and was received after the onset impose a time parameter the history and physical is most recent one." impoon, Employee #2 (the ied that if the history and results was not available, atment regardless. If AND COMFORT OF	I	574			
	This STANDARD is I	not met as evidenced by:					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		294506	B. WIN	IG _		09/0	4/2008
	OVIDER OR SUPPLIER	ELLC	•	STREET ADDRESS, CITY, STATE, ZIP CODI 2451 S BUFFALO DRIVE, SUITE #100 LAS VEGAS, NV 89117			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
I 574	Continued From page Based on observation a fire alarm system. Findings include: Observation On 9/4/08, there was available in the facility	n, the facility failed to provide no fire alarm system	1	574			
I 602	review plan that is im quarter to assess the	e in effect a written utilization plemented at least each necessity of services and ficient use of services	I	602			
	Based on interview at facility failed to have review plan implement assess the necessity	not met as evidenced by: nd document review, the in effect a written utilization nted at least quarterly to of services and to promote of services provided by the					
	review plan in place v specific written proce written procedures fo continued care, and c minimum, the criteria care policies (I605); v evaluating the applica	established in the patient written procedures for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		294506	B. WIN	B. WING		09/04/2008	
NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD HEALTH CARE LLC			•	2	REET ADDRESS, CITY, STATE, ZIP CODE 451 S BUFFALO DRIVE, SUITE #100 .AS VEGAS, NV 89117		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLETION	
I 602	procedures for evaluate clinical records with requality of services prowhether the facility's pare compatible and perficient utilization of cumulative effect of the resulted on the facility provision of quality he 485.66(b) UTILIZATION	ating the adequacy of the egard to assessing the ovided, and determining policies and clinical practices romote appropriate and services (1607). The nese systemic problems y's inability to ensure the ealth care. ON REVIEW PLAN plan must contain certain		602			
I 605	Based on interview and facility failed to have a which contained certar procedures for evaluation and the contained certar procedures for evaluation and the company of the utilization and the contained the contai	ation.	I	605			

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		294506	B. WING	3		09/0	04/2008
	OVIDER OR SUPPLIER	RE LLC		2451 S	ADDRESS, CITY, STATE, ZIP CODE S BUFFALO DRIVE, SUITE #100 /EGAS, NV 89117		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
I 605	Based on interview facility failed to have which contained we evaluating admission discharges using, a established in the pure linterview/Document On 9/4/08, Employ documented utilization and been no UR do 485.66(b)(2) UTILIZED.	is not met as evidenced by: and document review, the a utilization review plan ritten procedures for ons, continued care, and at a minimum, the criteria coatient care policies		605			
I 607	Based on interview facility failed to have which contained we evaluating the applitreatment to estable Interview/Documer On 9/4/08, Employ documented utilization had been no UR do 485.66(b)(3) UTILL.	-	16	607			

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` ′			(X3) DATE SURVEY COMPLETED	
294506	B. WING		09/	/04/2008	
RE LLC	24	151 S BUFFALO DRIVE, SUITE #100	ODE		
NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
h regard to assessing the provided, and determining 's policies and clinical practices d promote appropriate and	I 607				
v and document review, the ve a utilization review plan ritten procedures for evaluating e clinical records with regard to lity of services provided, and er the facility's policies and re compatible and promote ficient utilization of services. ht Review ree #3 stated there was no ution review (UR) plan and there					
	IDENTIFICATION NUMBER:	A BUILDING B. WING 294506 STR 24 L. STATATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) age 14 h regard to assessing the provided, and determining r's policies and clinical practices d promote appropriate and of services. is not met as evidenced by: v and document review, the ve a utilization review plan ritten procedures for evaluating the clinical records with regard to lity of services provided, and the rethe facility's policies and re compatible and promote fficient utilization of services. Int Review The service of the company of the	A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COL 2451 \$ BUFFALO DRIVE, SUITE #100 LAS VEGAS, NV 89117 STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) Regard to assessing the provided, and determining 's policies and clinical practices di promote appropriate and of services. Is not met as evidenced by: It and document review, the lity of services provided, and er the facility's policies and er compatible and promote ficient utilization of services. Int Review Interest ADDRESS, CITY, STATE, ZIP COL 2451 \$ BUFFALO DRIVE, SUITE #100 LAS VEGAS, NV 89117 ID PROVIDER'S PLAN OF CROSS-REFERENCED TO TO TAGE (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TAGE (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO TAGE (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO TAGE (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TAGE (EACH CORRECTIVE ACT) (EACH CORRECTIV	A BUILDING 294506 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2451 S BUFFALO DRIVE, SUITE #100 LAS VEGAS, NV 89117 STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) TAG PREFIX TAG PREVIDENCE TO THE APPROPRIATE DEFICIENCY) PREFIX TAG I 607 I 607	